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Veröffentlichungsversion / Published Version  
Zeitschriftenartikel / journal article

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### Empfohlene Zitierung / Suggested Citation:

Spree, R. (1980). The impact of the professionalization of physicians on social change in Germany during the late 19th and early 20th centuries. *Historical Social Research*, 5(3), 24-39. <https://doi.org/10.12759/hsr.5.1980.3.24-39>

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THE IMPACT OF THE PROFESSIONALIZATION OF PHYSICIANS  
ON SOCIAL CHANGE IN GERMANY DURING THE LATE  
19th AND EARLY 20th CENTURIES<sup>+</sup>

Reinhard Spree

Until the 1880s German physicians did not form a unified occupational group, but fell into a series of extremely heterogeneous groups. Given the different competing groups offering health services, the lack of a verifiable established expert knowledge prevented the formation of professional autonomy for the small subgroup of academically trained physicians. In the present essay I will show how doctors achieved this autonomy in the late 19th and early 20th centuries. During these decades the professionalization process of academically trained physicians accelerated being stimulated by their struggle against the putatively impending socialization of the medical occupation (statutory health insurance). At the same time I will elaborate upon the impact which the medical professionalization had on the long-term changes of the social structure. The main emphasis is placed on those aspects of change which are rather neglected in sociological and social historical literature and which can be regarded as the contribution of the physicians to the medicalization of the German society. By this I mean the rapid growth of receptivity of the population, especially the lower strata, for the so-called "medical culture" and thus for rationalistic patterns of values and behavior. Medicalization is seen as a function of the "Hidden Curriculum" of the system of social insurance and health-related infrastructure, which physicians helped to shape. Thus they contributed to the destruction of subcultures and to the homogenization of society in the area of values and behavioral orientations.

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1. CONSIDERATIONS ON PROFESSIONALIZATION THEORY

The features of the professionalization concept and the typical elements of the evolution of the medical profession in industrial societies during the last one and a half centuries, which are acknowledged as important, appear almost identical: achieving autonomy of the occupational body in respect to work content and mode of professional practice; control of entry to the profession as well as of content and form of training; authority over the division of labour within the professional sphere; achieving sociopolitical power through forming an association; establishing expert status; propagation of a particular professional ethic. This is not surprising, considering Freidson's emphatic statement, that

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<sup>+</sup> Paper presented to the 3rd SSRC/DFG North West Forum on German Economic and Social History, University of Liverpool, May 2nd, 1980. I am grateful to Angelika Schweikhart and Peter McLoughlin, who translated the original version into English.  
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if any occupational group constitutes a profession, then the modern physicians do.(1) Even though any such focusing of the professionalization debate on the medical profession appears for theoretical reasons problematical(2), nevertheless the established descriptive professionalization term is especially suited for a socio-historical consideration of the medical profession. This applies equally to that criterion, which Freidson considers the single selective criterion for a profession, namely the socially legitimized autonomous control of the work content.(3) Various studies of the evolution of the modern medical profession in different societies show, that the achievement of this professional autonomy in conflict with the state and its domination and on the other side with the competing claims of numerous social groups, which traditionally also dealt with health and illness, belong to the essentials of the process in question.

Larson has recently put forward an interesting extension of this approach. She considers the professionalization process as being analogous to a product innovation in Schumpeter's sense. The standardization of the market for a certain clearly defineable product would be therefore the decisive precondition of all efforts toward a professionalization. This product has to be standardized to such an extent, that an exclusion principle in regard to its creation may be carried through, which eventually leads to a standardization of the producers.(4) This principle (as precondition) can easily be generalized. Larson, however, makes clear, that in the case of physicians a variety of additional factors as pre-conditions of realization are involved, which in a specific historical manner can show different combinations and characteristics: for example the development of hospitals (especially the emerging combination of nursing of the sick, medical research and training of the junior staff); close relationship between the medical profession and the development of medical science and medico-technological advance; centralization and monopolization of the education of the trainees at universities; forming and fostering the ideology of the medical service to the public welfare.(5) Furthermore one other crucial intervening variable is necessary: suggesting to the public the notion of medical exclusiveness in respect to purposeful and efficient healing - this means, the belief in the medical superiority in the realm of diagnosis and therapy. Only if this belief is established can the profession arrive at a true monopoly for its supply of services (autonomy in Freidson's sense).(6)

Larson and other writers stress, that the dominant market position of physicians ultimately depends on the ideological foundations of the social reputation of medicine (7), Johnson on the other hand emphasizes, that there are objectifiable limits to potential developments of professional market strategies.(8) These must be seen in the economical and social-structural conditions for profitable capital use, for which the professionalization of a particular occupational group has to be functionalized. Doctors are given a monopoly on the definitions of health and illness in connection with professional autonomy, because the regulation of the labour market can be ideologically obscured by referring to the autonomous medicine.

The conditions referred to by Johnson and Larson, under which pro-

fessionalization processes unfold, and by which they become stamped in a specific way, can only be verified by historical national studies. In what follows, we will put forward the example of the professionalization of the German physicians in the late 19th and early 20th centuries, and make some references to the shaping of this process through the particular historical situation. It is necessary at the same time to elaborate upon the impact which the medical professionalization had on the long-term changes of the social structure. By doing so, we will touch upon facts which are regularly referred to in sociological professionalization studies (repression of the "competitors", "expropriation of health"). The main emphasis should therefore be placed on those aspects which are rather neglected in the professionalization literature and which can be regarded as the contribution of the physicians to the medicalization of the German society.(9)

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## 2. MEDICAL REFORM AND REPRESSION OF LAY MEDICINE IN THE MIDDLE OF THE 19th CENTURY

In his analysis of the status policy of the German physicians during the 1960's, Naschold explains the concern of the physicians about their status mainly in terms of the profession's historical emergence.(10)

For this purpose, he describes the status of the German physicians during the nineteenth century before the social insurance came into being. That would in the long term have caused a deterioration of their working conditions and a continuous threat to their social status. The initial situation is characterized by Naschold as follows: "The comparatively low level of medical research made relatively small demands upon the individual physician, who mostly worked as a general practitioner, in respect to scientific knowledge. In most cases the individual physician was able to comprehend the major areas of the medical subject and to have a rather good command of it. ... The physician had a regular clientele with little fluctuation. The modes of medical behaviour were stamped by 'authority and patriarchal solicitude' ... Autonomy and autarchy in their own profession, income in accordance with their social standing and a high prestige characterized the position of medicine in the nineteenth century."(11).

In what follows I will refer repeatedly to the results of Claudia Huerkamp's research, which depicts the situation of the physicians during the first half of the 19th century as follows: the physicians did not form a unified occupational group, but fell into a series of extremely heterogeneous groups, which in their turn can be roughly subsumed under a bipartition. The major part had no academic education, but had at best a craftsman's training: surgeons of different classes, barber-surgeons, barbers. The minor group had certainly completed studies at a medical department, but the medical knowledge was at that time largely concerned with symptoms and speculative. Therapeutical successes were highly uncertain and accidental. Hence it is impossible to speak of expertise based on specialized education, which could have secured them a professional

superiority over others, who offered medical services. If particular physicians enjoyed high social reputation, they did not owe this to their medical expertise, but to their social origins, their connections and their general knowledge, which raised them to the ranks of the "educated classes".(12) The great number of lay doctors is not included therein, whose clientele was recruited mostly from the lower strata of society and above all from the rural population in the country, which was "undersupplied" with physicians of all types. Among those lay doctors were: diviners, exorcists, magicians, alchemists, priests, lay brothers and sisters, midwives, old (wise) women, nuns, monks, dowers, and others.(13) Given the different competing groups offering health services, the lack of a verifiable established expert knowledge prevented the formation of professional autonomy for the smaller subgroup of academically trained physicians.

From the beginning of the nineteenth century until the formal restrictions for the therapeutic occupations were superseded by the Trade Regulation Acts of 1869 and 1871, a tendency to a unification and the emergence of dominance according to status can be observed within the two clearly distinguished groups of educated and licensed therapists, the academically trained physicians, enlarged by the more qualified surgeons, and the lower medical personnel. Between these two groups, the aforementioned had gained a clear dominance. Alongside them existed the disdained group of lay doctors, partly threatened by rules of the penal code or police regulations and increasingly viewed as "quack doctors". It should be emphasized that "the changing appearance of the pre-modern medical occupation - of which the most important feature was the existence of several subgroups, differing from each other by descent, education and status of their members as well as by the access to different clientele - was a process, set in motion by the bureaucracy of the state".(14) The commitment of the government in Germany could be so successful, because (even before the traditional appearance of the medical occupation was modernized)" in Germany, education took place at institutions which were supervised and financed by the state, and the examination board was appointed by the government".(15) Moreover, the licensed medical staff had an official or quasi official status up to the establishment of freedom of trade.

The implications for the social structure, which follow from the outlined development, appear at a first glance considerably important; above all they mark tendencies which developed to their full extent only in the subsequent decades. The changes appear most obvious in the structure of the supply of health services. The group of academically trained physicians was homogenized with respect to their socialization and social status by the integration of internal medicine, surgery, and obstetrics. Since the group altogether experienced an increase in status, the unification in this area can be interpreted as "collective social mobility upward".(16) Presumably, this group became now more homogenous in respect to their social descent, since the standards for entrance were raised (classical education) and a completed academic training was demanded. In this way, the so-called lower healing occupations were subsequently clearly demarcated from the physicians and were subjected to their dominance.

This process could be considered surprising, because up to then the strong status polarization within the medical occupations of the mid-nineteenth century and the insuring of the dominance of the physicians over the lower healing occupations, could not at all be justified by popularized progress of the medical science or socially appreciated improvements of medical diagnosis or therapy. The situation of medical therapy in the middle of the nineteenth century, moreover, is characterized by a "crisis of confidence", "which followed the therapeutical chaos of those decades." (17) A physician of the time noted: "The ancients were fortunate in having one remedy for an illness, and for many illnesses they had none. How much more fortunate we are! We not only possess infinite numbers of remedies for every single illness, but also every particular remedy now cures an infinite number of illnesses, and, thanks to research, we have especially for the most incurable illnesses the greatest number and the most effective remedies ... in fact, as far as I remember, only quite infallible ones". (18) In this situation the majority of people tended to have confidence in those groups of healers, who were legitimized by tradition and were socially closely associated with themselves. Furthermore, the social elites (nobility and upper strata of bourgeoisie), it can be supposed, were aware of the condition of medical research, which did not promise any superiority to the academic physicians. If this group nevertheless was privileged in a sense by the elites of society, and was granted a rudimentary professional autonomy (especially in relation to the groups of the depreciated healers), then the explanation for this can be seen in the states bureaucratic and authoritative interest.

This fact is indicated by Naschold, who writes: "The high status of physicians before the establishment of social insurance systems therefore did not rest only on privileges which were assigned to them because of their professional role, but to a high degree on the seigniorial structure of the society, which was dysfunctional to the health needs of the whole society". (19) Aspects of the seigniorial function of the standardization and relative rechartering of the medical profession (which were completed by 1869/71) could be based on the fact that, on the one hand, one subgroup of the educated bourgeoisie was socially revalued and symbolically indemnified. After the movements of social reform or even revolution during the 1840s there may have been good reasons for this. But even more important were on the other hand the results of the medicinal reform and the subsequent improvement of the infrastructural capacities of regulation and supervision (combat of epidemics; quarantines; poor relief) in accordance with the wishes of the health authorities. For such purposes and to consolidate the symbolic power executed by the respective social institutions, the pre-democratic (monarchic) German states did not require any scientifically qualified medical experts or clearly superior therapists. It was only necessary to endow the respective occupational group with sovereign appointed authority, given that the group had a limited number of members and was supervised by governmental participation in education and selection of applicants. These elements characterized the occupational role of the physicians in the mid-nineteenth century, which was so-to-speak determined by particular interests, and they may explain why the government rechartered the physicians. It was however not required to have expert knowledge, although Naschold, for example, considers this to be the constituent characteristic of the occupational role.

The institutionalized devaluation and the tendency to illegalize large numbers of healers (and thereby the knowledge and practices of lay medicine which they represented) can be seen as another element significant for the social structure. Structural changes in the entire society, induced by capitalist industrialization and urbanization, are crucially connected with the forfeiture of a direct feeling for nature and human body in vast groups of the society. The long-term development of the modern sciences, moreover, favours the rationalization and monopolization of the comparable empirical knowledge of the natural scientists. The governmental medicinal reforms in the mid-nineteenth century in Germany, by which the academically trained physicians were reevaluated and all other healers were devaluated to the point of illegality, intensified those tendencies in quite a concrete way. (20) Therefore, the physicians were given an anticipatory monopol in the increase in superior medical knowledge, which was to be expected only for the future. And in the same way encouragement was given to the alienation of the lower strata of society from the traditional healing knowledge and its inherent possibilities for self-aid. This process is foreshadowed, what is now called - with a glance to the more prominent effects in later decades - as "expropriation of health". (21)

In this respect the prohibition of different forms of lay medicine ("quackery"), which lasted until 1869/71, weighs especially heavily. Even in the subsequent decades, when the prohibition of "quackery" was abolished, many of the diagnostic or therapeutic procedures, some of which were quite serious but discredited by "classical medicine", could not rid themselves of the taint of illegality and inferiority. Considering the low density of physicians especially in the countryside, which continued to exist throughout the nineteenth century (despite some increases), and taking into account the cultural and financial limitations which prevented large parts of the population from visiting a doctor (even when one was available) the consequences of the medical reform in the mid-nineteenth century can only be assessed as a tendencial deterioration of the resources for the care of the sick in the urban lower classes and in the entire rural population. The long-term developments are more important than the short-term effects, which were hardly felt by the broad masses of the population.

### 3. INTEGRATION OF OPPOSING INTERESTS AND FORMATION OF THE PROFESSION IN OPPOSITION TO SOCIALIZATION TENDENCIES

The 1870s brought a turn to the development of the German physicians, one which is surprising even with the benefit of hindsight. At the instigation of the medical members of the Norddeutscher Reichstag, who referred to the petition of the Berliner Medizinische Gesellschaft, medical activity was declared a trade which anybody could practise. Only the title "physician" remained patented. Non-licensed persons were not allowed to lay claim to that or a similar designation. Simultaneously with this reformulation of Article 29 of the Trade Regulations Act, the Articles 199 and 200 of the Prussian Penal Code were abolished in a sort of barter, the so-called compulsion to heal (§ 200) and at the same time the "pro-

hibition of quackery" (§ 199). The legal rechartering of the physicians, especially the juridical repression of lay medicine was thereby partly made formally void. That physicians demanded and achieved the abolition of the inhibition of quackery appears to contradict a common assumption of professionalization theory. In this connection, Claudia Huerkamp pointed out that the physicians from Berlin who took the initiative were convinced, on the one hand, of the factual ineffectiveness of this prohibition. On the other hand, nevertheless, they belonged to the elite of that occupational group (a great number of university professors were participants) whose clientele could hardly be reached by the lay medicine. "All of the members of the Berliner Medizinische Gesellschaft were metropolitan physicians and were therefore not acquainted with the difficulties of country doctors, with whom non-licensed practitioners intensely competed". (22)

The high self-estimation of the Berliner Medizinische Gesellschaft and their intrepidity in the face of the competing lay medicine, however, reveal a novel tendency. Very likely, this self-estimation was not traditionally derived from the social standing of their clientele or their governmentally promoted authority, but resulted from the close connection with two developmental processes, which could be clearly recognized by physicians and the broad population only in the subsequent decades. On the one hand, medical science made essential advances and enjoyed considerable successes (which were partially overestimated in their propaganda), on the other hand, the movements for sanitation and welfare, for which the physicians were essentially responsible played an important role. Both developments enhanced the authority of physicians against the state as well as the society as a whole, and helped to gradually endow the physicians with an expert status. The progress of medical science made it possible to distinguish it from lay medicine not by mere legal chartering and social status (based on social descent and education) but also by objectifiable and popular superiority of healing knowledge and therapeutic achievement. The commitment to social policy and the self-attained authority which they increasingly enjoyed, even beyond their educational strata in the broad population, rendered their insistence on scientific legitimation and on expert status more serious.

The impact on the social structure, which was set in motion by the Trade Regulations Act is to be seen firstly in increasingly fervent contradictions among the physicians. The intra-professional frontiers which now opened up were those between panel doctors and non-panel doctors; less explosive but not at all unimportant in the long run, were those differences between general practitioners and specialists. In addition, conflicting interests arose between infirmary doctors on the one hand and free practising doctors on the other and between metropolitan and country doctors. It may have been the unintended but essential result of social insurance legislation, that all conflicting interests (which sometimes led to quite heated debates) as well as the underlying substantial differences in working conditions, amount of income, social status, and general conditions of life could be kept intraprofessional until the First World War. Such a situation allowed not only a formal unification of the medical profession, but also the organization of professional interest groups. Moreover, especially since the beginning of the 20th century, the profession could act as a relatively closed task force on behalf of all physicians.



Authors frequently stress that the establishment of statutory health insurance led to a significant expansion of the market for medical services. This argument is supported by two important implications of industrialization: on the one hand, the long-term increase of real wages among the lower strata and, on the other hand, the changing lifestyle concomitant with urbanization. It has remained largely unnoticed that the physicians consolidated themselves as a profession in the proper sense during the dispute with the panels (health insurance) from 1890 onward. As in this coercive expansion of the market the competition increased, the polarization of status advanced, and the long-term threat to status became graver, the cohesion of the occupational group - as expressed in the organization and debate within the association - grew stronger. Moreover, scientific and technological modernization processes could be incorporated into medical and educational reform and were presented to the public in the form of demands; additionally, an occupational ethos, which could be used as a trade mark, was developed and presented as propaganda to the public. The accelerated professionalization process acquires its ambivalent appearance (namely the combination of modernization demands and developments and tendencies traditionally directed against the market economy) in practical struggle against the ominous challenge of the panels - aiming to raise status through secure income and increased income respectively. Furthermore it is a puzzling fact, that the caste policy - oriented to restoring old privileges and fending off socialization tendencies in the realm of public health services - was carried through by the same means of agitation employed by the unions: strike, boycott, strengthening of the intra-associational ideology and supervision.

#### 4. RESISTANCE AGAINST THE ESTABLISHMENT OF A TREATMENT MONOPOLY FOR PHYSICIANS

Although the medical profession was quite successful during the early twentieth century in their struggle against the putatively impending socialization of the health services and the medical occupation, they could not restore the legally fixed monopoly which they had lost with the establishment of the trade regulations. Obviously, the physicians were not able until the First World War to convince either the public or the dominant elites of the necessity of such a privilege (prohibition of quackery). Since the 1880s the physicians increasingly became disgruntled, not so much because of the asserted (but never proved) loss of income caused by competing lay doctors; still less because of the lamented injury to the professional honour, which was said to be affected by questionable or clearly criminal practices of certain quack doctors. On the contrary, the fact was, that the medical demand for exclusive control of curative treatment was not even asserted in the health insurance legislation, neither in the first version of the act in 1883 nor in the subsequent amendments. In the late nineteenth and early twentieth centuries, it was quite possible that panels also remunerated so called quack doctors. Although the physicians fervently opposed such treatments in special cases, there is nothing known about the frequency of occurrence. Nevertheless, the occurrence depended partially upon the trade regulations, which

gave free access to healing occupations, and partially upon the very general formulation of the Health Insurance Act, the Sixth Article of which defined that from the beginning of the illness, among other benefits, free medical treatment is to be granted. In answer to inquiries of medical associations in 1887, the Staatsminister von Boetticher made a revealing statement before the Reichstag. He pointed out that the Health Insurance Act does not expressly state that the practice of therapy is allowed only to physicians. "Medical treatment" is understood as curative treatment in a general sense. If only physicians were to be admitted to treatment of members of the health insurance, then it would be necessary to change the wording of the act. (23) Such a reformulation of the act was explicitly rejected, since amongst the public, as von Boetticher pointed out, the need existed, in times of illness to seek help from non-medical persons, in whom the sick might have more confidence. As said before, this situation did not change juridically until 1914. It is however likely that the physicians were able gradually to enforce their notions by means of agreements with the panels establishing a de facto monopoly of treatment for licensed doctors.

The strategy of the physicians, to discriminate against the lay doctors by all means of public propaganda becomes thus more understandable. The following remark to this problem in the Health Report for the Prussian State in the Year 1901 is characteristic: "Considering the conceited arrogance and often unscrupulous irresponsibility of a great number of those inferior and dubious persons practising quackery, it is not surprising that the damage to life and health caused by them is considerable." (24) Evidence, of course, was not given for such serious and general accusations. Moreover, the hint that occasionally occur lay doctors, who had a previous conviction of damage to property or indecent assault, was the only argument. The fact that professional medicine, even at the beginning of the twentieth century, did not enjoy much authority among the broad population, and especially not in the countryside, follows not only from the great number of so-called quack doctors, who were made subject to forced registration at the instigation of the medical associations (it is, however, doubtful if this was widely observed!), but moreover from the fact that particular healing treatments, the cure affected by natural methods for instance, were entirely discriminated. Obviously it seemed necessary to oppose those treatments developing outside of the "classical medicine", because they spread quickly among the population in a kind of countermovement against the industrializing medicine and pharmacology. Advocates of such treatments and therefore competitors with the professional physicians were among others: "clergymen, craftsmen, herbalists, shepherds, failed students." The propagandistic fight was intensified especially against the elementary teachers, who attempted "to depreciate the scientific medicine" in public speeches and in clubs for the fostering of natural curing. (25) These considerations may be sufficient for making the assertion that an attempt, in accordance with the professionalization pattern, to carry through a legally established monopoly of treatment could not be accomplished until 1914 (except in peripheral branches as in vaccination, forensic medicine, public activities as experts in the medical field). The authority of the scientifically legitimized medicine had grown, but was not at all unchallenged or sufficiently widespread among the population.

Resistance to the monopoly of modern natural-scientific medicine came above all from two major groups: the rural population and the workers. The former scarcely came into contact with the real or purported successes of modern medicine. Geographic distance from physicians as well as low income and the absence of insurance encouraged a large measure of self-medication. Individuals relied on their own experience (for instance, experience in treating animals), household books, handed-down remedies, and the traditional healers and helpers of their own social milieu. There was little change in this regard up to the First World War.(26) Among the urban working classes, the same effect can be traced back to their cultural distance from medicine and its institutions, to their relationship to traditional forms of treating illness, and above all to the lack of finances. In light of the wide-spread poverty, the absence of prospects for a better life, and the phenomena of social disintegration, it is probable that among workers and among the urban lower strata in general a fatalistic attitude toward disease and infirmity was for a long time predominant. In this situation, the development and systematic expansion of social welfare institutions, especially of health insurance, tended towards a "prescribed social learning" - as v.Ferber calls it - the results of which can be described as "coerced socialization".(27) Although the motives of the organized workers' movement agreed with those of the official social policy in only a few points, it supported this "prescribed social learning" for the workers in regard to health care and took advantage of the corresponding infrastructural opportunities. During the period investigated here, this led to the increased integration of workers into the health care system and thus to a noticeable expansion of the market for medical services. Having anticipated this result, I would like in the following section to take a closer look at the motives and means for this "coerced socialization" of the lower strata.

## 5. COERCED SOCIALIZATION OF THE LOWER STRATA AND THE PROFESSIONALIZATION OF MEDICINE

In this final section of this paper, I should like to deal with the complex of "coerced socialization" somewhat more extensively, because it was presumably particularly effective in the area of the health care system and because doctors had considerable and continuous influence upon its development, propagation, organization, and practical implementation. The far reaching changes in social structure which were triggered by this process can be seen as directly connected with the efforts to professionalize medicine. These efforts have in turn received a great deal of support from the increased social credit of physicians and of modern medicine, which is due to the health care system.

During the last third of the 19th century in Germany, a catalogue of social-political measures was developed, which, together with the growing health-related infrastructure(28), gradually systematized the uncoordinated individual efforts and institutions. The important point here is that, over and above the immediate intensions of the catalogue, it had the function of "prescribed social learning" for the lower strata. Many of the measures to be considered here were

at first based on private initiatives of civil charitable associations, which during the later 19th century typically joined with representatives of the state or were complemented by state initiatives and which themselves took on executive authority or were taken over by the state. This development is merely a reflection of a process which took place in the society and economy as a whole, and which has often been discussed under the heading, development of "organized capitalism".

In order to facilitate a survey of this complex of institutions and policies, I have divided it into four broad areas according to the purposes of the actions taken:

- 1) regulation of the labor market (including the definition of temporary and lasting disablement),
- 2) social hygiene (with the subdivisions of urban sanitation, hygiene in trade and household),
- 3) social welfare (differentiated according to the major problem groups, such as mothers, infants, children, illegitimate children tuberculosis victims, drinkers and other marginal existences),
- 4) population policy (measures to promote fertility and to combat birth regulation, contraception, and abortion).

In this connection, a number of important individual measures should also be mentioned, such as for instance, mandatory vaccination for infants, binding regulations on social hygiene such as those in the area of central water supply and especially the removal of human wastes (for example, the introduction of toilets in the cities at least as communal toilets), the catalogue of regulations of the GKV (National Health Insurance) and of the social insurance (establishment of legitimized medical authority and control over the extent and form of temporary or lasting disablement; monopoly of doctors in the definition of illness and in regard to the social role of illness), measures for relief in the housing sector, serial medical examinations prescribed by law (for example with regard to fitness for military service or in the area of the public education system), medical examinations as prerequisite for employment (for instance, in the civil service), state supported campaigns to combat infant mortality, tuberculosis, drunkenness, etc. The social significance of these systematically complementing measures and institutions, which went beyond the intention of any particular action, is to be seen in the fact that they forcibly introduced those particular population groups to the principles and forms of a rationalized conduct of life, which had up to then scarcely come into contact with bureaucracies, with temporally and economically organized and regimented life-styles. The complex of social-political measures and the corresponding institutions resulted not only in a partly new kind of distribution of life-prospects or -chances based on infrastructural changes(29); they also massively confronted the lower strata with the so-called medical culture and with the mechanistic world picture which it expressed in practice.(30) In opposition to this, the "coerced socialization" in the army remained restricted to military drill and the implantation of blind obedience to military authorities. Furthermore the urban lower classes were included in it only to a very small proportion. The ideology indoctrinated in the army was characterized by militarism, by a notion of society derived from feudal estate and by a strong anti-modernistic attitude.(31) Therefore the "armed school of the nation" would scarcely have fostered the rationalization and modernization of private conduct of life.

The socio-structural implications of this process, which began to develop as "coerced socialization" even before the First World War and picked up momentum in the 1920s, had considerable importance not only for the professionalization of medicine and for the expansion of the market for the supply of medical services. Whereas at the end of the 19th century one could still ascertain a regional and class-specific "highly differentiated receptivity of the population for a more and more professionalized and industrialized medicine", in the early 20th century this gradually gave way to "a homogenization and standardization which complied with the expansion of medical therapy. Since at the same time the growth of the economy created the necessary economic opportunities for expansion, the medical-scientific culture could successfully be brought into the society".(32) The consequences are however even more extensive. The original, regionally and class-specifically differentiated receptivity for the "medical culture" was an expression of the existence of clearly differing subcultural life-styles and milieus, including corresponding value systems and behavioral orientations. It is scarcely to be imagined that the population was "homogenized" merely with regard to its receptivity for the offerings of medical services: rather, a more profound leveling and thus finally, a destruction of these subcultures must have taken place. The homogenization of society - at least in the long run - was apparently more radical in the area of values and behavioral orientations - that is, in areas essential to the life-styles of large groups of the population - than in the customarily cited areas expressed by socio-structural indicators such as occupation income, degree of education, etc.

Doubtless, a wide variety of factors contributed to this process. The physicians and the welfare movement, which they to a large extent instigated and carried out, can have constituted in themselves only a limited contribution. Nonetheless its importance should not be underestimated. This contribution, which was made above all through organizations and institutions (for instance the welfare system) and which did not take the form of a learning process as in the schools, was presumably more significant for the transformation of patterns of value and behavior than were the efforts carried out within the framework of formal education. We are dealing here with a kind of "Hidden Curriculum" which was established through the institutionalization and bureaucratization of the health system in the narrow sense and through the demands on behavior of the expanding health-related infrastructure in a wider sense and finally through the social welfare system. The effects of this "Hidden Curriculum" did not appear directly in the consciousness, in the intellects of people, rather they can be seen in a compulsion to behavioral changes, to a change in everyday activities.(33) The rationalization of life-style and the related transformation of values occurred to a large extent as an "unconscious process", as the sum of constraints on behavior.(34) Since the constraints were in turn connected to sensually experienced aspects of life and in general pursued goals which the individual could evaluate positively (aversion of pain, maintenance of health, lengthening of life, securing income, etc.), their chances of successful implementation would have been greater than those of demands for change of a moral or practical kind, which took consciousness as their starting point.

Thus the contribution of physicians and the process of their professionalization can be evaluated as relatively significant for this long-term social transition. Doctors were propagandists, executives and controllers of a variety of relevant everyday constraints on behavior, that is of the "Hidden Curriculum" of the infrastructure and of social welfare. For the process of the expansion of capital, they exercised a function similar to that of entrepreneurs and managers in the early factories with the aid of factory rules, differential wage systems, specific forms of the organization of labor, etc. Alongside these functions, which can be determined in relation to the needs of profitable expansion of capital within the framework of the capitalist process of production, the conscious complex of social-political measures and infrastructural institutions also had more specific functions, which are to be seen primarily from the standpoint of a particular social elite, namely the commercial and professional bourgeoisie. These measures and institutions clearly enabled exponents of this bourgeois elite to regiment, control, and "educate" the lower strata of the population. Besides the effect of social integration, which was also favored by exponents of the nobility at the end of the 19th century, the following goals, which were intimately connected to particular ideologies of the bourgeoisie, were also pursued: reduction of infant mortality, increased fertility (within marriage if possible), that is on the whole, growth of a potential labor power and military recruits; accommodation of the values and behavior of workers to bourgeois standards; neutralization of the workers' movement; implementation of "racial hygiene".

## 6. SUMMARY

The professionalization of German medicine during the late 19th and early 20th centuries apparently develops its specific dynamics precisely in a phase of social development characterized by a threat to the privileges of the bourgeoisie and to the health sector as a whole, which exposed especially the medical profession to the pressure of increasing tendencies towards socialization. The imagination with regard to organization and planning of a great number of doctors was not however limited during this period to the consolidation of medical organizations as combat units to establish professional autonomy, for clearly defined and in the long run increasing social status, or for an income appropriate to that status. Rather, by participating in the development of the system of social welfare and health-related infrastructure, doctors contributed - as a number of authors have emphasized - to a remarkable extent to the medicalization process of the German population. This process can be seen in the rapid growth of receptivity of the population, especially the lower strata, for the so-called "medical culture" and thus for rationalistic patterns of values and behavior. This function of the "Hidden Curriculum" of the social insurance and infrastructure system, which physicians helped to shape, went far beyond profession-specific goals, although such goals - especially the expansion and stabilization of the market for medical services - were also attained. In this light, the doctors can be seen as unconscious propagandists and promoters of a type of society

which has often - misleadingly - been called "nivellierte Mittelsstandsgesellschaft" (leveled/uniform middle class society). Since the late 19th century, the medical profession has again and again attempted to exclude itself as an elite cultural and income group from these "leveling tendencies". In this manner it has functioned as an exceptional agent for the patterns of values and behavioral orientations which support socio-structural homogenization.

#### FOOTNOTES

- 1 Freidson, 1970, p.4
- 2 Larson, 1977, p. 37 f.
- 3 Freidson, 1970, p. 82
- 4 Larson, 1977, pp. 20,35
- 5 ebd., pp. 24,37
- 6 ebd., p. 25
- 7 Freidson, 1970, p. 82; Larson, 1977, p. 23, Unschuld, 1978, pp. 532-540
- 8 Johnson, 1977, pp. 93-110
- 9 cf. also Imhof 1978, pp. 62-75; Ottmüller, 1979
- 10 Naschold, 1967, pp. 53-74, 89-106
- 11 ebd., pp. 90-93
- 12 Huerkamp, 1980
- 13 Unschuld, 1978, p. 530
- 14 Huerkamp, 1980
- 15 ebd.
- 16 ebd.
- 17 v.Ferber, 1975, p. 14
- 18 Fechner cited by Ackerknecht, 1970, S. 122
- 19 Naschold, 1967, p. 94
- 20 Ottmüller, 1979
- 21 for example Freidson, 1970, p. 371; Unschuld, 1978, p. 530 f.
- 22 Huerkamp, 1980
- 23 according to von Littrow, 1970, p. 439
- 24 Das Gesundheitswesen des Preussischen Staates im Jahre 1901, p. 495
- 25 ebd., p. 494
- 26 v.Ferber, 1975, p. 40
- 27 ebd., p. 44-48
- 28 Spree, 1980
- 29 Spree, 1979

- 30 v. Ferber, 1975, pp. 46 f.
- 31 Wehler, 1973, pp. 158-164
- 32 v. Ferber, 1975, p. 48
- 33 Gleichmann, 1979
- 34 Imhof 1978, pp. 67-72

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